STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT LAKE CITY	415 CHINWORTH COURT WARSAW, IN46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for Investigation of Complaint IN00090476. Complaint IN00090476 - Substantiated. State deficiencies related to the allegations are cited at R091, R0116, and R0119. Survey dates: May 26, 27, and 31, 2011. Facility number: 011389 Provider number: 011389 AIM number: N/A Survey team: Diane Nilson, RN Census bed type: Residential: 23 Total: 23 Census payor type: Other: 23 Total: 23 Sample: 3 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on June 3, 2011 by Bev Faulkner, RN	R0000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Dificiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, perparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by this facility of the truth of any facts alleged or the correctness of any conclusions set forth in this alligation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to ensure policies and procedures regarding abuse prohibition were followed in regard to reporting of allegations of abuse and failed to include in the policy the need to report allegations of abuse directly to the administrator. This involved CNA #1, CNA #7, and LPN #1 for not reporting CNA # 6 or QMA # 4. Findings include: 1. The Residence Director (Administrator) and Wellness Director were interviewed, on 5/26/11, at 12 noon, and indicated there had been no incidents of any abuse reported to them since they had been employed at the facility. LPN #1 was interviewed at 12:11 p.m., on 5/26/11, regarding the abuse protocol. The LPN indicated a former CNA #1 had reported an incident of verbal abuse to the	R0091	R 091There have been no further accusations of verbal abuse since the survey.Staff will report observed or suspected abuse immediately to the Residence Director and/or Wellness Director. The Regional Director of Operations and/or the Regional Director of Quality and Care Management will then be notified. The policy has been amended to reflect the reporting structure.Staff will be retrained regarding the policy and procedure for reporting observed or suspected abuse.New staff members will be trained regarding the policy and procedure for reporting observed or suspected abuse as part of the initial training and orientation.The Regional Director of Operations and/or the Regional Director of Quality and Care Management will review the documentation regarding an allegation of abuse during routine house visits at least monthly to ensure that the policy and procedure was followed.Completion Date	07/17/2011

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	LPN involving Resident A. The LPN indicated she was not aware of the date of the incident, but it occurred while CNA #1 was still employed at the facility. The LPN indicated CNA #1 had worked night shift, and reported the incident to her at change of shift, and indicated CNA #1 reported she witnessed CNA #6 and QMA #4 verbally abuse Resident A, by yelling at her. LPN #1 indicated she told CNA #1 to report the incident of verbal abuse to the Wellness Director, but LPN #1 indicated she did not report the incident herself. CNA #7 was interviewed at 12:20 p.m., on 5/26/11 and indicated she had witnessed CNA #6 being verbally abusive and loud to residents. CNA #7 indicated about 1 month ago, she observed CNA #6 "grab" Resident B by the hand and said, "not right now, you don't need that, go sit down. " CNA #7 indicated CNA #6 was loud when she was talking to the resident. CNA #7 indicated after the incident occurred, Resident B just sat down and took her hand away. CNA #7 indicated she did not report this incident to anyone. CNA #7 indicated she had observed QMA #4 call Resident A "Lucy" and whenever QMA #4 referred to Resident A, she		7/17/2011.	

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	would call her "Lucy. " CNA #7 indicated she asked QMA # 4 why she referred to Resident A as "Lucy" since that was not the resident's name, and QMA #4 indicated it stood for "Lucifer. " CNA #7 indicated she did not report this to anyone. The Residence Director was interviewed at 2:10 p.m., on 5/26/11, and indicated he had been employed at the facility since mid April, 2011, and the Wellness Director had started 3 days prior to his employment. He indicated if there was an incident of resident to resident or staff to resident abuse reported, he would notify the Regional Clinical Nurse Consultant, and she would advise him rather to report the incident to the Indiana State Department of Health (ISDH). He further indicated if there was a very obvious staff to resident abuse reported, he would report the incident to ISDH and then notify the Regional Clinical Nurse Consultant. Review of the facility policy "Suspected Abuse/Neglect/Exploitation," on the afternoon of 5/26/11, the policy indicated, "Any complaints of abuse, neglect, or exploitation should be viewed as very serious and must be reported to your Regional Director of Operations and or (sic) Regional Director of Quality and			

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	Clinical Services immediately." The policy also indicated the following: If abuse, neglect, or exploitation of a resident was suspected, act immediately to protect the resident from additional harm, and "call your Regional Director of Operations for assistance as soon as possible "; Upon instruction from your Regional Director of Operations, contact the appropriate State agency as soon as possible during the required reporting timeframe; Consult with your Regional Director of Operations to determine what information to provide in case a written report was required by state regulations; Any staff member may notify the appropriate state agency of suspected/alleged abuse, neglect or exploitation without fear of retribution; If the Residence Director or his/her designee did not report the incident to the State, a staff member should. However, the employee should first verify with the Residence Director that the incident has not already been reported before contacting a state agency. Facility staff did not follow the policy of reporting abuse. The policy did not address first contacting the Administrator/Residence Director of the facility prior to contacting the Regional			

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	Director of Operations and/or Regional Director of Quality and Clinical Services. This residential deficiency relates to complaint IN00090476.			
R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the	R0116	R 116Gardens at Lake City will complete a criminal background check for new applicants. In	07/17/2011

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	facility failed to have procedures in place to further investigate negative criminal history checks for 1 of 7 employees files reviewed. (Former Residence Director) Findings include: 1. The employee files were reviewed for the abuse protocol at 2:30 p.m., on 5/26/11. The employee file, for the former Residence Director, contained a negative limited criminal history report, dated 1/25/11. The current Residence Director (Administrator) was interviewed at 9:25 a.m., on 5/27/11, and indicated he didn't know if there was any inquiries made regarding follow-up on the negative criminal history check for the former Residence Director, and that someone from the corporate office would be in contact. The Regional Director of Operations for the facility was interviewed by telephone at 12:24 p.m., on 5/27/11, and indicated he did not know if there was any follow-up completed regarding the negative criminal history check, and didn't know the company policy regarding this. He indicated someone from Human		cases where there is a negative criminal history, Human Resources will be contacted promptly prior to hire.The policy reads that an offer of employment is contigent on a negative criminal background check.Documentation of the background check will be maintained in the personnel record.The Divisional Director of Human Resources has retrained the Regional Director of Operations regarding this policy on 5/31/2011. The Residence Directors will be retrained by 7/17/2011.The Regional Director of Operations and/or the Regional Director of Quality and Care Management will review a sampling of new employee files at least monthly during house visits to ensure that the background check was completed and if a negative criminal history is discovered, that it has been referred to Human Resources.Completion Date 7/17/2011.	

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	Resources would be in contact next week. The Divisional Director of Human Resources for the corporation was interviewed by telephone at 10:00 a.m., on 5/31/11. She indicated the former Administrator (Residence Director) was hired on 1/14/11, on an interim basis and indicated the "complaint" regarding the negative criminal history report was not discovered until later. She further indicated she would email the policy on background criminal history checks. The Wellness Director was interviewed at 1:45 p.m., on 5/31/11, and indicated she had communicated with the Director of Human Resources and the corporate legal department, and was told the company followed the Indiana State Department of Health policy, however, the Wellness Director indicated she could not find the policy regarding hiring and screening of employees. This Residential deficiency relates to complaint number IN00090476.			

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R0119	(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure 6 of 7 employees whose employee files were	R0119	R 119Gardens at Lake City will provide training regarding abuse for new employees prior to working independently.The training will be completed using the Staff Training Guide. Training regarding abuse will take place	07/17/2011

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	reviewed were oriented to the abuse policy prior to working with the residents. (CNAs # 1, 2, 3, 4, 5, 6.) Findings include: 1. The employee files were reviewed on 5/26/11 at 2:30 p.m. Six of the 7 employee files reviewed did not contain evidence of abuse prevention training: CNA # 1, a former employee, hired on 10/14/10, and terminated on 5/10/11; CNA #2, hired 5/17/11, first day worked with residents, 5/18/11; CNA #3, hired 5/11/11, first day worked with residents, 5/16/11; CNA #4, hired 3/6/10; CNA #5, hired 5/12/11, first day worked with residents, 5/16/11; CNA #6, hired 11/22/10. The Wellness Director was interviewed on 5/27/11 at 9:50 a.m., and indicated she was unable to find documentation CNA's #1, #4, and #6, had received abuse orientation prior to working with the residents. She indicated she was hired on 4/11/11, and was responsible for inservicing and abuse training for the employees. She indicated she had not inserviced CNA's #2, #3, and #5 regarding the abuse policy.		on the first day of orientation per the traning policy.Documentation of such training will be maintained on the Staff Orientation and Training Record and will be placed in the personnel record.The Residence Director will monitor documention for new employee training as an ongoing QA process to ensure that the policy and procedure is being implemented.The Regional Director of Operations and/or the Regional Director of Quality and Care Management will review orientation and training documentation on new employees during routine house visits at least monthly, until consistent compliance is achieved.Completion Date 7/17/2011.	

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	The "Staff Orientation and Training Record" policy was provided by the Wellness Director, on 5/31/11 at 1:45 p.m. Review of the policy,at 1:45 p.m. on 5/31/11, indicated it was expected that all staff received a timely and thorough orientation, and included a set of topics, which was to be signed by the employee as it was completed. The topics of abuse, neglect, and exploitation were listed on the new employee orientation. This residential deficiency relates to Complaint IN00090476.			